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**AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

1. Child's (client's) full name ____

2. Date of birth ______________________________
   Address____

3. Date of authorization commencement _________________________ Authorization will expire six (6) months from commencement date, unless otherwise specified in writing.

4. Authorization initiated by: ____

5. Authorization is being given for: _____ one-way communication _____ two-way exchange

   ____ in writing ____ verbal _____ release of therapy notes

6. Purpose of disclosure: I am authorizing disclosure of confidential information because
   ____
   ____
   ____
   ____

7. Persons authorized to receive the Disclosure from Dr. Zelinger (include name, address, phone) ____
   ____

   Authorization and Signature: I authorize release of my child's confidential protected psychotherapy notes, as described above. I understand that this information is voluntary and can be revoked at any time if supplied in writing and if it has not already been shared.

   Parent (s) name: *print* _______________________ *signature*_________________________

   print _______________________ *signature* _________________________

   Comment: ____